

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE/Ellicott c. LENGTH OF STAY IN lb 13-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHAFFER CONVALESCENT RETREAT, INC.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE d. STREET ADDRESS BONNIE VIEW LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last ABEL, SR.		4. DATE OF DEATH Month JULY Day 29 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1897
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 10 Days 29 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BALTO. TRANSFORMER	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS ABEL		14. MOTHER'S MAIDEN NAME SELDA FRITZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-0243	
17. INFORMANT MRS. MARGARET A. ABEL		Address BONNIE VIEW LANE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Occlusion 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiac Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-13 , 19 66 , to 7-29 , 19 66 that (I) (we) last saw the deceased alive on 7-23 , 19 66 , and that death occurred at 9:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Herbert		22b. DATE SIGNED 7-29-66	
22c. PHYSICIAN'S NAME (Type) THOMAS F. HERBERT, M.D.		22d. ADDRESS 44 CHURCH ROAD, Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-1-66	
23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		ADDRESS 4107 WILKENS AVENUE 21229	
25a. REC'D BY REGISTRAR AUG 3 1966		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

10001

EXHIBIT IN CASE

10001



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10012 CERTIFICATE OF DEATH 10004											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Dorward Co</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakland Nursing Home</u>						d. STREET ADDRESS <u>834 Stamford Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Marie</u> Last <u>Birnie</u>						4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/17/1883</u>		9. AGE (in years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Galena, Md.</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Mulford</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Alice Liles 203 Hopkins Road</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4200</u> DUE TO (b) <u>Arterio-sclerotic hrt. dis.</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic hrt. dis.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1966</u> to <u>July 10, 1966</u> that (I) (we) last saw the deceased alive on <u>July 10, 1966</u> and that death occurred at <u>3:04</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Christian S. Vass</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/11/66</u>											
22c. PHYSICIAN'S NAME (Type) <u>BALTIMORE NAT'L. PIKE & ST. JOHN'S LANE</u> <u>ELICOTT CITY, MD.</u> 22d. ADDRESS <u>687 Balto, Nat'l Pike Ellicott City</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/12/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. J. Tichner & Sons</u>						ADDRESS <u>Balto. 1 Md North 2 Pl.</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 13-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore National Pike 9 Pine Orchard						d. STREET ADDRESS Baltimore National Pike (Pine Orchard)				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula		First May		Middle Blacksten		Last Blacksten		4. DATE OF DEATH Month July		Day 11	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1890		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Louis Yingling						14. MOTHER'S MAIDEN NAME Susan Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Evelyn Affeldt, Cemetery Lane, E.C. Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pelvis with generalized 1972 DUE TO metastasis, diverticulitis with rupture of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diverticulum, colostomy and cardiac arrest. (c) July 11, 66 INTERVAL BETWEEN ONSET AND DEATH 1865											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 11, 1965 , to July 11, 1966 , that (I) (we) last saw the deceased alive on July 11, 1966 , and that death occurred at 7:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE Howard E. Hall						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.						22d. ADDRESS Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-14-1966		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery				23d. LOCATION (City, town or county) (State) Uniontown, Md			
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md						25a. REC'D BY REGISTRAR JUL 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakland N/Home		d. STREET ADDRESS Rt 11 Box - 40	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN M. BORN		4. DATE OF DEATH Month Day Year July 10 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 14 March 1890
9. AGE (In years lost birthday) yrs. 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Emerick		14. MOTHER'S MAIDEN NAME Mary (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-65-0113	
17. INFORMANT Emory J. Born #1 Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 578X IMMEDIATE CAUSE (a) Upper & lower ectostical bleeding & Jll bleeding DUE TO (b) Unresected DUE TO (c) Unresected Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Grucal adeno sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 1966 to July 10, 1966 , that (I) (we) last saw the deceased alive on July 10, 1966 and that death occurred at 3:45 M. from causes and on the date stated above.			
22a. SIGNATURE Charles S. Judge		22b. DATE SIGNED 7/10/66	
22c. PHYSICIAN'S NAME (Type) BALTIMORE NAT'L. PIKE & ST. JOHN'S LANE ELICOTT CITY, MD.		22d. ADDRESS 687 Balto. Natl. Pike - Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/13/66	23c. NAME OF CEMETERY OR CREMATORY Balto. Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Maryland
24. FUNERAL DIRECTOR Singleton Funeral Home/ Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 90		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N.Y.		b. COUNTY Woodhaven	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oakland Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 8616 75th Street	
3. NAME OF DECEASED (Type or print) First Amelia		Middle L.		Last Comfort		4. DATE OF DEATH Month July		Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1883		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Antone Schubert					14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Harry F. Tourte, 120 Dunloggin Rd. E.C. Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conjunctive heart failure DUE TO (b) Arteriosclerosis DUE TO (c) General arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 6/27, 1966 to 7/5, 1966		21. I certify that I (the hospital) attended the deceased from 6/27, 1966 to 7/5, 1966 that I (we) last saw the deceased alive on 1966 , and that death occurred at PM , from the causes and on the date stated above.	
22a. SIGNATURE Christian S. Mass, M.D.		22b. DATE SIGNED 7/5/1966		22c. PHYSICIAN'S NAME (Type) Christian S. Mass, M.D.		22d. ADDRESS 687 Balto. Nat'l. Pike, Ellicott City		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8, 1966		23c. NAME OF CEMETERY OR CREMATORY Cypress Hill		23d. LOCATION (City, town or county) (State) Brooklyn, N.Y.		24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md.	
25a. REC'D BY REGISTRAR JUL 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

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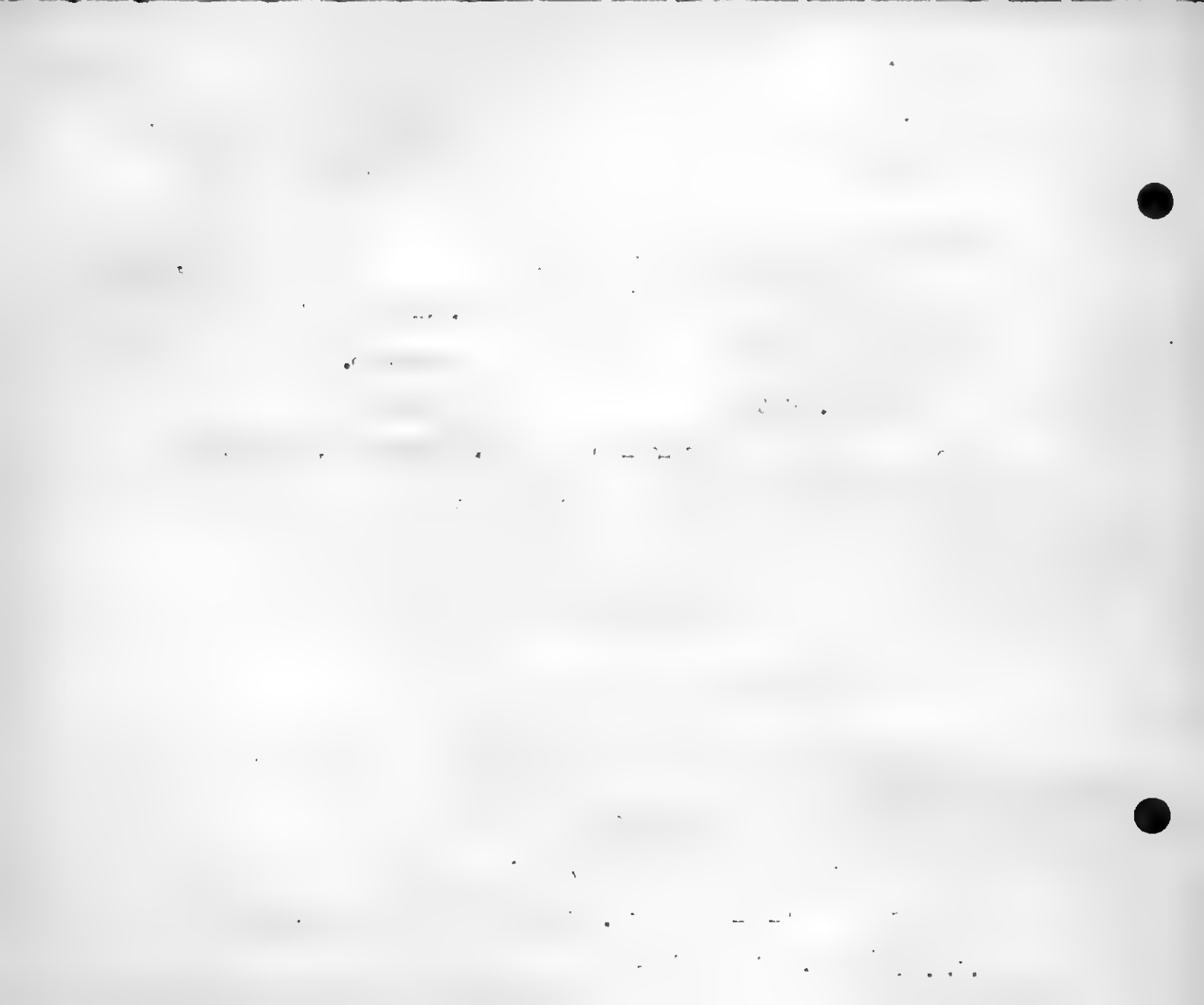
VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
10016					CERTIFICATE OF DEATH					10008				
1 PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE c. LENGTH OF STAY IN 1b ELKRIDGE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5828 VIRLONA AVENUE 21227					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE d. STREET ADDRESS 5828 VIRLONA AVENUE 21227, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3 NAME OF DECEASED (Type or print) First Middle Last LOUISE E. CONTER					4 DATE OF DEATH Month Day Year JULY 4, 66									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-1890		9. AGE (In years lost birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) LUXEMBOURG			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME PIERRE BAUSTERT					14. MOTHER'S MAIDEN NAME ELIZABETH									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MR. JULES G. CONTER, 5828 VIRLONA AVENUE #27							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-vascular disease 4221 DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO Heart Ex-haustion (c)										INTERVAL BETWEEN ONSET AND DEATH 2 mo. 1 day.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 29, 1966 to July 4, 1966 , that (I) (we) last saw the deceased alive on July 4, 1966 , and that death occurred at 5:20 M, from causes and on the date stated above.														
22a. SIGNATURE DR. BRUCE BRUMBAUGH					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/6/66							
22c. PHYSICIAN'S NAME (Type) DR. BRUCE BRUMBAUGH					22d. ADDRESS 5609 MAIN STREET									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 7-7-66		23c. NAME OF CEMETERY OR CREMATORY ST. AUGUSTINE'S CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229					25a. REC'D BY REGISTRAR JUL 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Howard MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HOWARD Middle GRAFTON Last CRIST					4. DATE OF DEATH Month July Day 9 Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1892		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Howard Co. Md		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edward L. Crist					14. MOTHER'S MAIDEN NAME Rachel Hobbs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 216-36-6139		17. INFORMANT Address Mrs. Irene Crist, Glenelg, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/5/ , 1960, to 7/9/ , 1966, that (I) (we) last saw the deceased alive on 7/8/ , 1966, and that death occurred at 1 AM, from the causes and on the date stated above.									
22a. SIGNATURE Charles S. Whitaker						22b. DATE SIGNED 7/11/66			
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.						22d. ADDRESS Clarksville, Maryland 21029			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7-12-1966		23c. NAME OF CEMETERY OR CREMATORY Mt. View		23d. LOCATION (City, town or county) (State) Alpha, Md		
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md						25a. REC'D BY REGISTRAR JUL 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clarksville c. LENGTH OF STAY IN 1b Clarksville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Trotter Road						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clarksville d. STREET ADDRESS Trotter Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First VIOLA Middle L. Last CROSBY						4. DATE OF DEATH JULY Month Jan. Day 24 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1900		9. AGE (in years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas Howlett						14. MOTHER'S MAIDEN NAME Australia Dow					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Ella Mae Burke, Trotter Road, Clarksville Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Hypertensive vascular dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabet. Mellitus INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 1962 to July 24, 1966 , that (I) (we) last saw the deceased alive on July 24, 1966 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE E. S. MASS						22b. DATE SIGNED 7/24/66		22c. PHYSICIAN'S NAME (Type) E. S. MASS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-26-1966		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn		23d. LOCATION (City, town or county) (State) Norfolk, Va			
24. FUNERAL DIRECTOR F.C. Higinbotham, Elicott City, Md.						25a. REC'D BY REGISTRAR JUL 27 1966 25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

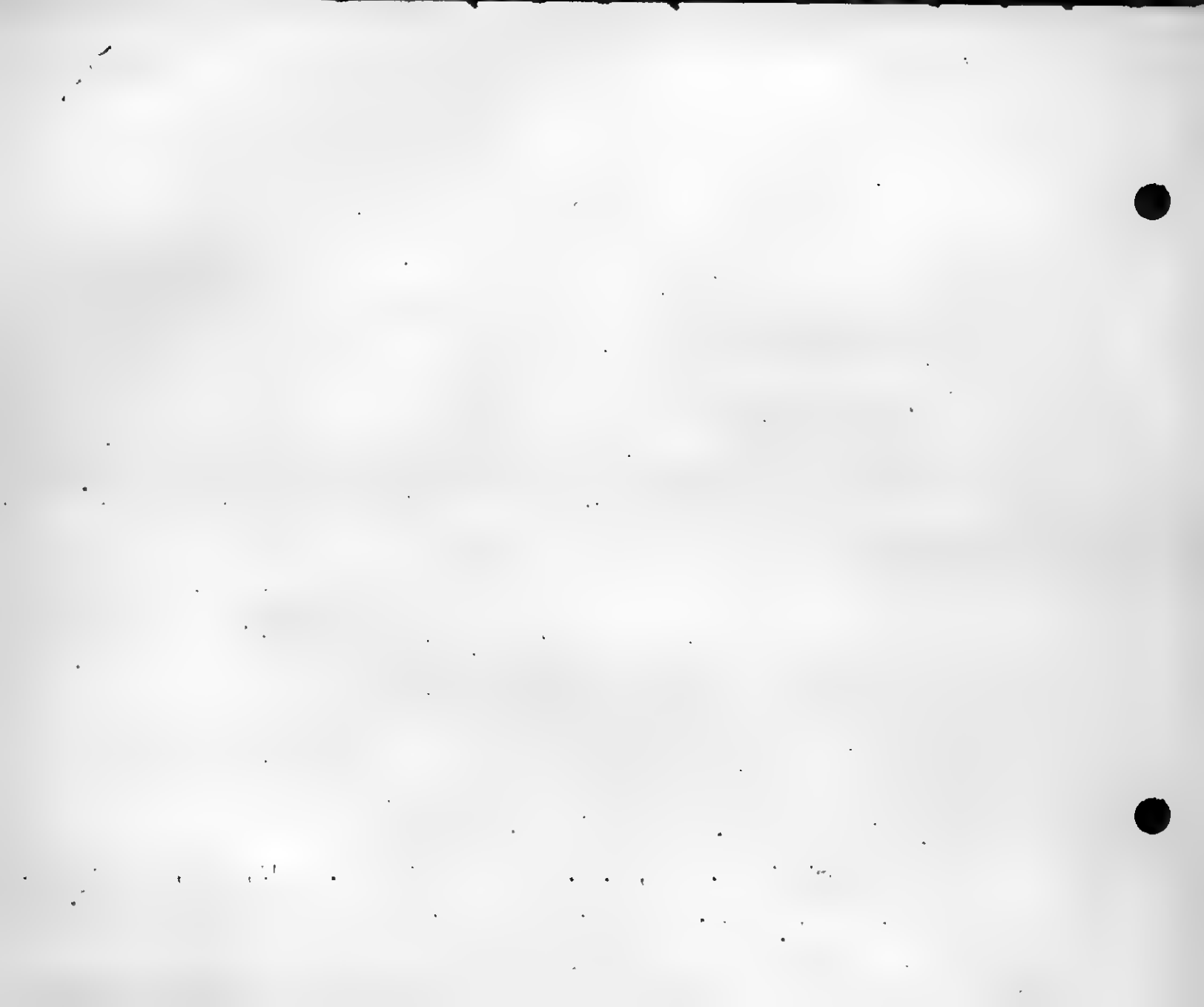
<div>Items 18-21 Film 379 8-17</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div>									
<div>10019</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>10011</div>									
1 PLACE OF DEATH a COUNTY HOWARD MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLCOTT CITY c LENGTH OF STAY IN 1b					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) TAYLOR MANOR HOSPITAL					d STREET ADDRESS 4028 Deepwood Road 21218			e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last HELINDA ELIZABETH DALBKE					4 DATE OF DEATH Month Day Year 7 16 19 66				
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 13, 1918		9 AGE (in years last birthday) 48 yrs		10 IF UNDER YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher			10b KIND OF BUSINESS OR INDUSTRY School		11 BIRTHPLACE (State or foreign country) W. Va.		12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME W. H. S. White (dec)					14 MOTHER'S MAIDEN NAME Grace Yoke				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16 SOCIAL SECURITY NO		17 INFORMANT Raymond R. Dalbke, husband		Address 4028 Deepwood Rd. Baltimore, Md.		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metabolic imbalance associated with chronic ethylism and withdrawal from ethylism 3221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Russell S. Fisher M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					Address (Street, city, town, or county)				
22. DATE SIGNED 7-16-66									
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b DATE THEREOF 7-19-66		23c NAME OF CEMETERY OR CREMATORY Elmwood Cemetery			23d LOCATION (City or Town) (County) (State) Shepherdstown, Jeff. Co.		
24 FUNERAL DIRECTOR E. George Davis					ADDRESS Charles Town, W. Va.		25a REC'D BY REGISTRAR JUL 19 1966		25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10020						10012					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Howard						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City						b. COUNTY Anne Arundel					
c. LENGTH OF STAY IN 1b 2 Mos. +						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cakland Nursing Home						d. STREET ADDRESS Rt. #2 - Box #640 (Margate)					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last Wilhelmina C. Freburger						Month Day Year July 6, 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1895		9. AGE (In years last birthday) 71 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, & foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Sadler						14. MOTHER'S MAIDEN NAME (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Edward L. Freburger (Husband)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 41 DUE TO (b) DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis - Ht. dis. 10 years General arteriosclerosis Myocardial infarction - asthma						INTERVAL BETWEEN ONSET AND DEATH 2 days					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from July 15, 1966, to July 6, 1966, and that death occurred at 11:35 M. from the causes and on the date stated above.											
22a. SIGNATURE Christian S. Mass, M.D.						22b. DATE SIGNED 7/7/66					
22c. PHYSICIAN'S NAME (Type) Christian S. Mass, M.D.						22d. ADDRESS 687 Balto. Nat'l. Pike, Ellicott City					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF July 9, 1966			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park			23d. LOCATION (City, town or county) Md. (State) Glen Burnie Md.		
24. FUNERAL DIRECTOR T.L. Singleton						25a. REC'D BY REGISTRAR Glen Burnie Md.					
						25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10021		Item 2 Film 6348 7/14/66 mh		10013	
1. PLACE OF DEATH a. COUNTY HOWARD		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) TAYLOR MANOR HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ELLICOTT CITY/ Reisterstown 21136	
3. NAME OF DECEASED (Type or print) First Middle Last MILTON S. GLICK		4. DATE OF DEATH Month Day Year 7 12 1966		5. SEX MALE	
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME HARRY GLICK		14. MOTHER'S MAIDEN NAME ANNIE WEINBERG		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. MR. GABE GLICK, 7239 PARK HEIGHTS AVENUE #8		17. INFORMANT Address MR. GABE GLICK, 7239 PARK HEIGHTS AVENUE #8	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure Conditions, if any, which gave rise to immediate cause (b) Coronary insufficiency with angina (c), stating the underlying cause last. Arteriosclerotic CV disease		INTERVAL BETWEEN ONSET AND DEATH 8 hrs 4 yrs Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizoaffective Psychotic - periodic excitement		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OCT. 27, 1965	
20f. (City or town) July 12, 1966		20g. (County) 4508		20h. (State) MD	
21. I certify that (I) (this hospital) attended the deceased from... saw the deceased alive on... 22a. SIGNATURE IRVING J. TAYLOR, M.D.		22b. DATE SIGNED July 12, 1966		22c. PHYSICIAN'S NAME (Type) IRVING J. TAYLOR, M.D.	
22d. ADDRESS TAYLOR MANOR HOSPITAL, ELLICOTT CITY MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/13/66		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	
23d. LOCATION (City, town or county) BALTIMORE, MARYLAND		23e. REC'D BY REGISTRAR JUL 14 1966		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN		24a. DATE JUL 14 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Items 18-21 Film 379 8-10 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10014

1 PLACE OF DEATH a COUNTY Howard		b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Jessup		c LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b COUNTY Harford	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Perkins State Hospital				d STREET ADDRESS Concord Apartments e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First JAMES		Middle CHRISTOPHER		Last KILGALON		4 DATE OF DEATH Month July Day 13 Year 19 66	
5. SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 7-1935	
9 AGE (In years last birthday) 40		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b KIND OF BUSINESS OR INDUSTRY Nursing		11 BIRTHPLACE (State or foreign country) Washington D.C.	
12 CITIZEN OF WHAT COUNTRY U.S. A.		13 FATHER'S NAME James C. Kilgaler		14 MOTHER'S MAIDEN NAME Catherine Andrews		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT Laura E. Kilgaler		Address 414 C. Blay 3 - Concord Towne Harford, Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcohol - Disulfiram Reaction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		MEDICAL CERTIFICATE	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Ingestion of alcohol while receiving disulfiram therapy.		20c TIME OF INJURY Month, Day Year Hour a.m. 6:45 7 12 19 66		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Jessup		(County) Howard		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Petty		M.D.		22. DATE SIGNED 7/14/66		EXAMINER'S NAME (Type) Charles S. Petty, M.D.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7/18/1966		23c NAME OF CEMETERY OR CREMATORY Arlington Md.		23d LOCATION (City or Town) Arlington Va.	
24. FUNERAL DIRECTOR Primmington & Son, Harford, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUL 20 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10023

10015

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>OAKLAND NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>1707 TAYLOR ST NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>URIA</u> Middle <u>B</u> Last <u>REYNOLDS</u> 4. DATE OF DEATH <u>July 10 1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 25, 1889</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov.</u> 11. BIRTHPLACE (County & State or foreign country) <u>OHIO</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>ABNER REYNOLDS</u> 14. MOTHER'S MAIDEN NAME <u>IDA WALTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT <u>Mrs Landman</u> Address <u>1212</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4200</u> DUE TO <u>Arteriosclerotic ht. dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Multiple myeloma (?)</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>July 10 1966</u> 20d. INJURY OCCURRED <u>at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>at work</u> 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 28, 1966</u> to <u>July 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 10, 1966</u> , and that death occurred at <u>3:02 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Christian S. Mass</u> 22c. PHYSICIAN'S NAME (Type) <u>Christian S. Mass, M.D.</u> 22b. ADDRESS <u>687 Balto. Nat'l. Pike, Ellicott City, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>July 12, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> 23d. LOCATION (City, town or county) <u>Wheaton, MD</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JUL 13 1966</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

BZ

10024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10016

1 PLACE OF DEATH a. COUNTY Howard MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN b. Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Davis Road				d. STREET ADDRESS Davis Road			
3 NAME OF DECEASED (Type or print) HENRY CLAY SCRIVNER				4 DATE OF DEATH July 11, 1966			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-22-1880	9 AGE (in years last birthday) 86 yrs	10 IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill		11 BIRTHPLACE (State or foreign country) Carroll County, Md		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-09-6144		17. INFORMANT Elwood Scott, Davis Road, Ellicott City, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arterio-sclerotic Cardio Vascular Disease DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE George E. Burgtorf		M.D. George E. Burgtorf		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 7-12-1966	
EXAMINER'S NAME (Type) George E. Burgtorf		M.D. George E. Burgtorf		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-14-1966		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City or Town) (County) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham				25a. REC'D BY REGISTRAR JUL 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10025					10017				
1. PLACE OF DEATH a. CDUNITY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City			c. LENGTH OF STAY IN ID		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City			d. STREET ADDRESS 3 Font Hill Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3 Font Hill Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First RUTH Middle E. SHUBERT Last			4. DATE OF DEATH Month July Day 1 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-1890		9. AGE (in years last birthday) 75 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hartleton, Pa.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ammon A. Loss					14. MOTHER'S MAIDEN NAME Emma Lucas				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Joseph C. Boulder, Ellicott City, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 154X DUE TO Uccclusion of ureters Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cx of ureters & retention of fluid (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized debilitation									INTERVAL BETWEEN ONSET AND DEATH 1 month 5 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 30, 1965 to JUNE 30, 1966 , that (we) last saw the deceased alive on JUNE 30, 1966 , and that death occurred at 12:30 M. from the causes and on the date stated above.									
22a. SIGNATURE Irving Scherlis					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) IRVING SCHERLIS					22d. ADDRESS 25-Read St Balk 241				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7-6-1966		23c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery		23d. LOCATION (City, town or county) (State) Grand Junction, Colo.		
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md.					25a. REC'D BY REGISTRAR DATE JUL 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

FC.

Higinbotham, Ellicott City, Md.
for Henry Funeral Home, Honey Grove, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10026

10018

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton		c. LENGTH OF STAY IN ID MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Penna b. COUNTY Adam		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gettysburg		d. STREET ADDRESS Rt. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUDEN SAMUEL YOCUM		First		Middle		Last		4. DATE OF DEATH Month July Day 6 Year 1966		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1902		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 7 Days 5 Hours 3 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? Penna		13. FATHER'S NAME Samuel Yocum		14. MOTHER'S MAIDEN NAME Minnie Barkley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. 193-01-5350		17. INFORMANT Albert D. Yocum, Rt 4 Gettysburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>George E. Burget</i>		EXAMINER'S NAME (Type) George E. Burget		M.D. Church Road Ellicott City, Md		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED July 6, 1966					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-9-1966		23c. NAME OF CEMETERY OR CREMATORY Mc Cullochs Mills		23d. LOCATION (City, town or county) (State) Tuscar Township, Penna.		24. FUNERAL DIRECTOR Higinbotham, Ellicott City, Md.		25a. REC'D BY REGISTRAR JUL 11 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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